



**Royal college: it's your call, says president**

**Pharmacist CD prescribing under consultation**

- LPC conference: new PSNC chairman revealed
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## News

4-10

### Royal college: not compulsory

4

RPSGB president Hemant Patel confirms there is no mandatory membership requirement in the Lambeth view of a future professional leadership body

### Pharmacist prescribers 'will deliver'

5

Proposed regulation changes would enable the prescribing of morphine by IP pharmacists and nurses

### Pfizer clashes with MSP over discount claim

6

Firm clashes with politician over comments that it had agreed to review its discount structure in Scotland

### Patients prosper under pharmacy contract

8

Forty per cent of Avicenna members say services have improved under the new contract

### Contractors win £450k 'back pay' claim

10

Pharmacists in Northern Ireland are to receive back-dated dispensing fees after threatening legal action



## Features

12-29

### Pharmacy Champion 12

Mark Green has set up a minor ailments scheme in Doncaster

### Over to you 26

This year's LPC conference was the last for outgoing chairman Barry Andrews

### Hear no evil 29

David Reissner reports on a case involving diuretics and appetite suppressants

### Howzat for Barbados

Bon Viveur takes the love 34 of his life to the Caribbean for a meal in spectacular surroundings

## Opinion

14-16

### Editor's comment

Your Views

Xrayser

Black Bag

## Clinical

17-22

### Pharmacy Update:

Dry mouth

A Practical Approach:

Medicines in

pregnancy

Clinical news:

Antibiotics in children

Hardening of arteries in

smokers reversible

## Products & Marketing

23-24

Pollenshield; Bic; Poligrip Ultra; Zantac; QuickStrip; Pronamel; Zovirax; Understanding Eczema

## Classified & Recruitment

30-33

### Star Job:

Full time pharmacy technician (dispensing) required, NW6 area of London

### What's on TV

24



# Royal college: it's your choice

**RPSGB** No mandatory membership in Lambeth view of future professional leadership body

Max Gosney

**Pharmacists will be given a choice** on joining a royal college led by the Royal Pharmaceutical Society, the RPSGB president has told C+D.

Hemant Patel ruled out compulsory membership under Lambeth's plans to form the professional leadership body set out by last month's White Paper on healthcare regulation. He said: "I do not see membership as mandatory in the sense that they [pharmacists] will have to join like a regulatory body. But, I do see a vast majority of pharmacists joining on a voluntary basis because they feel compelled to be members."

Mr Patel said he had "no idea" of membership fees to support his royal college proposals. However charges are likely to rise from the RPSGB's current £283 per year retention fee and £137 new member fee, he revealed.

The Society is committed to a "timely consultation" with pharmacists before advancing its royal college plans, Mr Patel stressed.

"No decision will be taken by this president or this Council without consulting the membership." The RPSGB will seek views by post, regional branch meetings and a series of roadshows, he added.

Mr Patel opened the door to working with other pharmacy organisations to achieve his vision of



Hemant Patel: committed to a 'timely consultation' with pharmacists on royal college proposals

a royal college supporting pharmacists faced with growing clinical roles. But, the Society must be the linchpin of any joint initiative, he warned

"We are not arrogant or assuming anything and are working with other partners like the CPP. But, if we see a situation where specialist groups form a royal college that would be a disaster. To be a viable organisation it has to be built around the Society."

## Hemant has his say on:

**The end of the RPSGB?** "It's possible changing to a royal college could see a name change at the Society. I think that people should be more concerned about functions of the organisation at the moment."

**His future:** "I've been on the political scene longer than I expected and I plan to come off the Council in 2008. I'd like to carry out work with practice development and spend a bit more time watching cricket."

**Possible job cuts:** "Every member of staff that is flexible and committed will still be in employment."

**The GPC:** "I believe it's beneficial for the GPC and royal college to colocate. There's a number of opportunities for joint working and there are cost benefits."

## The president's royal college plan

### To create an organisation that aids:

- The development of standards of practice and performance
- The development of standards of education and training
- Support for CPD including facilitation, reviews and continuing education/skills development training
- Support for revalidation, both to meet initial revalidation

requirements and additional support for those whose initial assessment is not satisfactory

- Those wishing to return to practice after a break, or to move to advanced or specialist levels
- Help for clinical supervision and mentoring
- Support for early days of practice and movement between specialisms or areas of practice

# CPP hands royal college baton to RPSGB

**Legislation** Organisations withdraw from race to be representative body and unite behind Society

**Specialist pharmacy groups have** agreed to unite behind the RPSGB in its bid to lay the foundations for a pharmacy royal college.

Twenty organisations, including the College of Pharmacy Practice, confirmed that they still wish to be an integral part of a representative body, but conceded that the RPSGB and PSNI should lead the way.

Earlier this month the CPP outlined plans to evolve into a royal college. Chief executive Ian Simpson said: "We've got to be pragmatic about it. We're really not in a position to automatically become the royal college and nor, indeed, do I think we should."

At a meeting convened by CPP on March 15 at the Union Jack Club in Waterloo, the groups agreed that a

royal college should have a role in revalidation but that membership should be voluntary and extended to all pharmacy occupations.

They also pointed to the need for the profession to have a single cross-sector trade union body,

similar to the BMA for GPs.

The stance – known as the Waterloo Agreement – was presented at a private seminar at the King's Fund on March 20 and formed part of a submission to Lord Carter's White Paper review. It will be

supported by a private website to facilitate discussion between the groups.

Mr Simpson said: "It's an opportunity for all organisations in pharmacy to come together to form a royal college." **TH**

## The Waterloo Agreement

### Present:

- Association of Pharmacy Technicians UK
- British Oncology Pharmacy Association
- College of Mental Health Pharmacists
- College of Pharmacy Practice
- Faculty of Neonatal and Paediatric Pharmacy
- Faculty of Prescribing and Medicines Management
- Guild of Healthcare Pharmacists
- Institute of Pharmacy Management
- Neonatal and Paediatric Pharmacists' Group
- Primary Care Pharmacists' Association

- Pharmacy Law and Ethics Association
- UK Clinical Pharmacy Association
- UK Medicines Information
- UK Psychiatric Pharmacy Group

### In agreement:

- NHS Pharmaceutical Aseptic Services Group
- NHS Pharmaceutical Production Committee
- NHS Pharmaceutical QA Committee
- Technical Specialists Education and Training Committee
- UK Radiopharmacy Group

# Pharmacists back CD prescribing

**Medicines** Patients will benefit under plans to widen scope of prescribers

Jane Ellis

## Pharmacist independent

prescribers have pledged huge improvements in patient care if moves to lift restrictions on the prescribing of controlled drugs become law.

Westminster has launched twin consultations on the prescribing of controlled drugs and the supply of morphine and diamorphine under patient group directions by nurses and pharmacists.

The proposals aim to free pharmacists' potential to provide pain relief, according to the DH. Pharmacy minister Lord Hunt said: "Enabling nurse and pharmacist prescribers to prescribe those controlled drugs they are competent to use, allows these highly trained professionals to use their full range of skills to help their patients. The proposed changes will allow nurses and pharmacists to give pain relief quickly and safely to patients who need it."

Independent prescribers said the

proposals will lead to improved treatment for many conditions.

David Thompson, an IP at Boots in Bournemouth who specialises in addiction treatment, said: "It will certainly make my job a lot easier as it will remove the need for a clinical management plan and allow the pharmacy to become a one-stop shop, supplying both methadone and an aqueous cream or salbutamol to the same patient."

Maresh Sodha, supplementary prescriber and pharmacist at Colecross Pharmacy in Chelmsford, said: "I am sure that those independent prescribers who work in the area of drug abuse, chronic pain management and palliative care will be able to help their patients better if these restrictions are lifted."

As part of the government's proposals the Home Office will lead a 12-week study into updating the misuse of drugs regulations to enable the prescribing of morphine by IP pharmacists and nurses.

A second MHRA consultation will investigate freeing CD prescribing



Lord Hunt: pharmacists could offer fast and safe pain relief for patients under proposals under PGDs, the DH said.

Hemant Patel, president of the Royal Pharmaceutical Society was excited by the proposals.

"I think it's a very interesting move and opens up lots of opportunities for pharmacists to deliver palliative care. Extending prescribing rights will improve the quality of care available to terminally ill patients."

Details at [www.mhra.gov.uk](http://www.mhra.gov.uk) and [www.homeoffice.gov.uk](http://www.homeoffice.gov.uk)

## News in brief

### Win £300 with C+D

C+D is going green in May with a whole month of environmental news and information.

You can play your part by doing the C+D Big Green Survey and entering for a £300 prize. For more information visit [www.dotpharmacy.com](http://www.dotpharmacy.com)

### Patients tell pharmacists

The Community Pharmacy Patient Questionnaire, from the PSNC and the DH will be sent out in the next edition of PSNC Community Pharmacy News. It is also available to download from [www.psn.org.uk](http://www.psn.org.uk)

### New PSNC chairman

Christopher Hodges takes over from Barry Andrews as PSNC chairman on September 1. Dr Hodges has worked in the pharmacy sector for more than 16 years. He is vice-chairman of the Association of British Healthcare Industries and co chairman of two working groups of the Health Industries Task Force.

### New code of ethics

The RPSGB has announced changes to its code of ethics which encourage pharmacists to play a more inclusive part in healthcare, public health and social care. The revised code will be presented to the Society's AGM in May, with a view to launch on August 1, 2007.

### Contract will last

The CCA has told the government that the community pharmacy contract "is robust and will stand the test of time".

In its evidence to the Galbraith Review, CCA CEO Rob Darracott said: "In PCTs where pharmacy based services are being commissioned, everyone is winning. What we need is more of the same."

### Anticoagulant safety

The National Patient Safety Agency wants pharmacists to ask patients for INR results before dispensing anticoagulants. The request is part of a package of measures aimed at cutting the current toll of 480 serious harm events and 120 deaths each year due to medical errors concerning anticoagulants.

# Boots rebrands amid takeover talk

**Retailing** Multiple to spend £65m on 'your local Boots pharmacy' project

Tom Hawkins

**Alliance Boots unveiled a £65m** programme to refit and rebrand its community pharmacy network this week as speculation over a takeover bid rumbled on.

The company plans to badge the majority of its 900 community stores as 'your local Boots pharmacy' by summer 2009. The concept, which has been trialled since October, allies Boots' retail offering with a tailored

focus on community pharmacy services.

Chief executive Richard Baker hailed the move as "the biggest single expansion of the Boots brand in its history".

The plans were outlined in a bullish pre-close trading update issued on March 28 in which the company said it was confident it would hit full year targets. Both dispensing volumes and the number of MURs increased in the last three months.

The news comes amid speculation that Boots could be subject to a fresh takeover bid to rival the £9.7bn offer tabled by private equity firm KKR and executive deputy chairman Stefano Pessina on March 9.

At the release of the update, chief executive Richard Baker excluded talk of a sale. He added that the executive team was in complete agreement over the combined group's merger strategy, which was making "good progress".

Mr Baker said the firm had identified 100 areas where overlaps between Boots and Alliance outlets would lead to certain stores being relocated closer to surgeries or health centres and a limited number being sold.

He added that, despite the post-merger disposal of 96 pharmacies hampering its capacity for acquisitions, Boots had stepped up its purchasing rate, adding 16 stores since January.

Mr Baker said: "We have delivered against our plans for bringing our businesses together, for continuing to grow them successfully and for delivering the initial merger cost synergies."



Carrying it out: Boots aims to rebrand more than 900 stores by 2009

## News in brief

### Temporary chief for NPA

The NPA has revealed that Colette McCreedy will temporarily fill in as chief executive while the hunt for a permanent replacement for John D'Arcy continues.

Ms McCreedy, currently director of pharmacy practice, was asked to take up the role by the NPA board on Wednesday. She will work alongside Mr D'Arcy until his departure on April 31.

Ms McCreedy said it was too early to say whether she would consider the role on a full-time basis.

### Split cost warning

The RPSGB has warned its members that any split will have "implications for registration and retention fees in the coming years".

Speaking at the Society's Council meeting this week, secretary and registrar Ann Lewis said: "The government's white paper proposals have placed considerable demands on the Society's resources, both human and financial."

### RPSGB director leaves

Beverley Parkin has left her position as director of public affairs and communications at the RPSGB, the Society has confirmed.

### Alzheimer's drug review

The High Court has granted permission for a judicial review of Nice decision not to recommend anti-dementia treatments for newly diagnosed mild Alzheimer's disease. Eisai Ltd, the licence holder for the Alzheimer's drug donepezil applied for the judicial review in early January.

The Alzheimer's Society has been given leave to contribute to the court proceedings.

### Pack changes

Over-the-counter pack sizes of analgesics containing codeine and dihydrocodeine have been restricted to a maximum of 32 tablets or capsules, according to the latest RPSGB law & ethics bulletin. The MHRA has also asked manufacturers to update the patient information on all such products to include warnings in relation to addiction and overuse. For full details visit

# Pfizer clashes with MSP over discount claim

**Scotland** Company states it has no plans for a discount review

Wesley Yin-poo

**Pfizer has clashed with an MSP** over comments that it had agreed to review its discount structure north of the border.

Mr Stewart Stevenson MSP told C+D that he received the assurance following a meeting on March 6.

However, in a statement, Pfizer said it had no plans to conduct a review at the moment.

A spokesperson said: "In future, however, we would expect to regularly review our investment in discount schemes."

Harry McQuillan, chief executive officer of the Scottish Pharmaceutical General Council, said he had no knowledge of any plans from Pfizer to look at discounts to Scottish

pharmacists, but would in principle welcome a review.

Mr Stevenson met with Pfizer after pharmacists in the north of Scotland raised concerns over having to deal exclusively with UniChem, which has no distribution depots north of Livingston.

Despite Pfizer's statement, Mr Stevenson said he expects to hear back from Pfizer in early April, and expressed his commitment to taking the matter further if he is not satisfied with their reply.

He said: "I would certainly pursue it up the chain. I'm prepared to go all the way to the top."

UniChem said it was matching delivery frequencies given to pharmacies prior to Pfizer's direct to pharmacy deal.



Stewart Stevenson: prepared to "go all the way to the top" in discount dispute

## RPSGB slams P to POM plan

**RPSGB** Ephedrine change 'an insult' says Society

**The RPSGB has angrily refuted** MHRA proposals that could spell the end for products containing pseudoephedrine being sold OTC, calling it a "professional insult".

The MHRA has recommended switching medicines containing pseudoephedrine and ephedrine from P to POM because of a rise in its use in the manufacture of methylamphetamine.

Speaking at the Society's Council meeting this week, president Hemant

Patel slammed the move as a "gross overreaction".

At the meeting, the Council unanimously voted to strongly oppose the proposal and agreed to control the potential for widespread misuse by retaining P status and tightening control through pharmacy.

The Society suggested limiting the maximum pack size to 720mg pseudoephedrine/ephedrine and to one pack per purchase. **WYP**

## PSNC chair tells Lord Hunt: 'You're wrong'

**PSNC** Rift over national minor ailments scheme

**Outgoing PSNC chairman Barry Andrews** has clashed with Lord Hunt over claims there should be no national requirement for a minor ailments scheme.

Speaking at the PSNC dinner in London's Royal Lancaster Hotel, Mr Andrews responded to comments Lord Hunt made in an exclusive interview with C+D earlier in the month by warning that without national direction, there was the risk of a "patchy, piecemeal approach" to pharmacy services.

Mr Andrews also called on pharmacists to be commissioned to provide a service to identify people with weight problems and a national EHC and chlamydia screening service.

He said: "We would like to see them as advanced services under the contract – in other words, nationally agreed and funded, and implemented in partnership with PCTs locally." **WYP**



Be prepared: public health minister Caroline Flint urged all businesses to gear up for compliance with the smoking ban which starts in England in July. The DH is sending out guidance and no smoking signs to 1.7 million firms

Barry Andrews opened the LPC Conference last week. See page 26

# "A NASAL SPRAY FOR ALL HAYFEVER SYMPTOMS? YOU'RE PULLING MY LEG!"



Some customers think a nasal spray is just for nasal symptoms. So make sure they know that times have changed for hayfever treatment. A once daily dose of Flixonase Allergy Nasal Spray is effective for itchy eyes<sup>1-4,10-12</sup> and beats once daily antihistamine tablets hands down on relieving sneezing, runny nose, nasal congestion and groggy head.<sup>1-9</sup> What more could they want?

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and bronchospasm. Very rarely glaucoma, raised intraocular pressure and cataract. Extremely rarely nasal ulceration and nasal septal perforation usually following previous nasal surgery. **Pregnancy and lactation:** Do not use except with medical advice. **Legal category:** P. **Product licence number:** PL 10949/0360. **Product licence holder:** Allen & Hanburys, Stockley Park, Middlesex, UB11 1BT. Further information available on request from Medical and Consumer Affairs, GlaxoSmithKline Consumer Healthcare, Brentford, Middlesex, TW8 9GS. **Package quantity and RSP:** 60 spray pack £6.99. **Date of preparation:** June 2006. **FLIXONASE®** Face and Air Device are registered trade marks of the GlaxoSmithKline group of companies. **References:** 1. Ratner PH *et al. J Fam Pract* 1998; **47**: 118-125. 2. Stricker WE *et al. Ann Allergy Asthma Immunol* 1998; **80**: 115. 3. Kaszuba SM *et al. Arch Intern Med* 2001; **161**: 2581-2587. 4. Jordana G *et al. J Allergy Clin Immunol* 1996; **97**: 588-595. 5. Gehanno P, Desfougères J-L. *Allergy* 1997; **52**: 445-450. 6. Weiner JM, Abramson MJ, Puy RM. *BMJ* 1998; **317**: 1624-1629. 7. Foresi A. *Allergy* 2000; **55** (Suppl 62): 12-14. 8. Stricker WE *et al. J Fam Pract* 1994; **38**: 14-22. 9. Vervioet D, Charpin D, Desfougères J-L. *Clin Drug Invest* 1997; **13**(6): 291-298. 10. Bernstein DI *et al. Clin Exp Allergy* 2004; **34**: 952-957. 11. Van Bavel JH *et al. Ann Allergy Asthma Immunol* 1997; **78**: 128. 12. Damall R *et al. Clin Exp Allergy* 1994; **24**: 1144-1160.

# 60pc rise in pharmacists reporting better services

**Contract** Services on the up, but contractors feel down

Ailsa Colquhoun

**The new pharmacy contract** benefits patients more than the profession, Avicenna members have said in a poll.

Responding to the group's pre-conference survey, over 40 per cent of members said they felt the contract had enabled them to improve patient services this year. Citing the availability of services such as medicines use reviews and standard operating procedures, the 2006-07 figure compares to just 25 per cent who felt this way during year one of the contract.

However, the contract has done little to improve relationships with patients or GPs. Only a third of the 77 respondents believed it had improved relationships with patients and only 13 per cent with GPs. Pharmacists cited paperwork and bureaucracy as the main reason for failure.

Staff and time management issues are also said to have had a negative impact on pharmacists' working conditions. Critically, only two in five pharmacists felt optimistic about their future generally, and under half

about their financial prospects.

Commenting, Avicenna chief executive Salim Jetha said: "The new contract has certainly helped to improve patient services but it has come at a cost. This has brought about a degree of pessimism over profits and outlook. Recent changes in the distribution model (Pfizer) may have contributed to this.

"Managing the change to new ways of working is taking time – but independents will come off strongly. Independents want very much to be in the forefront of healthcare."



Salim Jetha: new contract has come at a cost

## Limit 100-hour applications, says Avicenna

The 100-hour exemption has led to some undesirable effects and should be subject to local control, Avicenna has said in its response to the Galbraith review into the control of entry regulations.

It pointed out that in some 100-hour operations, the pharmacist is only contactable by a buzzer. It also believed that some are only providing 80 hours' service and that PCTs were unable to adequately monitor compliance. It has called for PCTs to be able to control exempt applications via a local needs assessment or via a reinstated necessary or desirable test.

It added that pharmacists need certainty and stability if they are to provide the services that will allow the government to transfer services from secondary to primary care. "There is no evidence to suggest that there is a lack of competition or choice," said Avicenna director Uma Patel.

**10%**  
The number of pharmacists in discussions with GPs over PBC

**17%**  
The number of pharmacists who have had a professional service withdrawn by their PCT

**50%**  
The number of pharmacists providing smoking cessation services

**44%**  
The number of pharmacists with plans to become an independent prescriber or take on a special interest

**61%**  
The number of pharmacists complaining about stress

## News in brief

### Code clarification

The Company Chemists' Association is seeking further clarification on the standards for registered pharmacists and pharmacy technicians in positions of authority. In its response to the RPSGB consultation on the guidance notes to the new Code of Ethics it points out that it should be mandatory for pharmacy superintendents to be resident in the UK.

### Prescription instruction

Welsh prescriptions (WP10 series) dispensed on or after April 1 should not attract a prescription charge, the Welsh Assembly Government has said. The NHS (Free Prescriptions and Charges for Drugs and Appliances (Wales) Regulations 2007 do not apply to FP10 series prescriptions. Patients with a valid Welsh pre-payment certificate should apply to the issuer for a refund, WAG advised.

## Nucare seeks City backing

**Industry** Symbol group looking for AIM flotation to remedy 'difficult' year

Max Gosney

**Nucare is set to float on the stock** market in 2007 as the symbol group seeks to remedy "extremely disappointing" end-of-year profits.



Michael Major: eyeing up the stock market

Flotation on the AIM market will fund Nucare's growth plans as well as delivering value to shareholders, according to the group's annual report.

The move follows a slump in post-tax profits to a 10-year low of £179,000. Nucare non-executive chairman Michael Major said business had been hit by the group's struggling wholesale business, which was sold in May, 2006.

"We are mindful of our commitment to deliver liquidity for shareholders and I am pleased to report we are now able to move towards a stock market listing," he said.

"Our wholesaling business continued to be a drain on resources and profits. Although the group's final profits for the year were extremely disappointing, I am very pleased to report that the underlying continuing operations for our retail and services divisions saw record results," Mr

Major added.

Nucare has secured a £12 million loan to support pharmacy acquisitions over the coming year, Mr Major revealed. The group will also be "investing heavily" in its professional services and IT offers, he added.

"There are still opportunities for us to grow, particularly as some of the older style buying groups are struggling to meet the growing diversity of the market."

However, Nucare must keep debt at a "serviceable level", the Nucare chairman warned.

Maresh Shah, Nucare chief executive officer, added: "We are dedicated to developing services and programmes which will deliver strong returns to us as a business, whilst also benefiting our members."

Total remuneration for Nucare's seven directors increased to £541,726, 2006 figures revealed.

# Is their medication ending up where it should be?

Dysphagia, or swallowing difficulty, is a much more widespread problem than you might think.<sup>1</sup> It leaves many people, especially the elderly, struggling to swallow their medicine and often leads to it being thrown away.

Such non-compliance has serious consequences in that it can lead to poor outcomes, hospitalisation or even patient death.<sup>2</sup> It also costs the NHS over a billion pounds a year in wasted medicines and the costs associated with adverse clinical outcomes.<sup>3</sup>

That's why it makes sense to give people who can't swallow solid medicines a more appropriate formulation such as a liquid - and the sooner this is done the greater the difference it can make in terms of improved compliance and patient welfare.

Rosemont specialise in liquid medicines offering solutions across a wide range of therapeutic areas.



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#### References:

1. Strachan I, Greener M. Medication-related swallowing difficulties may be more common than we realise. *Pharmacy In Practice* December 2005. 2. Richard Griffith, Medication Management and the law 2 – Residents With Medication Related Dysphagia 2006. 3. Greener M. *JME* 2006; 9: 27-44.

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Information about adverse event reporting can be found at [www.yellowcard.gov.uk](http://www.yellowcard.gov.uk) Adverse events should also be reported to Rosemont Pharmaceuticals Ltd on 0113 244 1400.

## News in brief

### EPS pilot

The Department of Health and Connecting for Health have invited applications to take part in EPS release 2 pilots.

PCTs must express an interest before May 17 to take part in tests for the advanced phase of the paperless prescription system, according to the DH. For more information visit [www.dh.gov.uk](http://www.dh.gov.uk)

### Co-op most ethical

The Co-op has been named the UK's most ethical business in a study by GfK NOP, which investigated how brands are perceived by consumers in the UK, France, Germany, Spain and the US.

UK consumers perceived the Co-op's treatment of staff, care for the environment and support for fair trade as key to it being an ethically driven business.

### Diabetes for you

A personalised 'information prescription' should be available to everyone with diabetes, an online report published this week has said.

'Information Provision in Diabetes', from the ABPI in association with Ask About Medicines Week and Diabetes UK, said patients should also be able to access up-to-date information to enable them to understand their condition and treatment options.

A PDF only version is available at [www.abpi.org.uk](http://www.abpi.org.uk)

### Free condom offer

Rowlands will start giving out free condoms across its 440 pharmacies from May as part of its aim to improve sexual health awareness.

As part of a joint initiative with SSL, Rowlands branches will display leaflets. Customers will receive sample condoms and a condom facts leaflet.

### Free scripts in Wales

Rhodri Morgan, Welsh first minister, has said that free prescriptions in Wales from April 1 is the "biggest move in decades" to improve the health of the people of Wales.

The move will also resolve health inequalities in Wales and reduce costs to the NHS, said Mr Morgan.

# Contractors win £450k 'back pay' claim

**Northern Ireland** DHSSPS reverses decision on cuts after threat of legal action

Ailsa Colquhoun

**Pharmacy contractors in Northern Ireland** are this month to receive £450,000 in back-dated dispensing fees after representatives made the unprecedented move of threatening pharmacy ministers with legal action.

Pharmacy representatives, the Pharmaceutical Contractors Committee, threatened the Department of Health, Social Services and Public Safety with a judicial review after it wrote to contractors on January 26 advising that it was to reduce the instalment (multiple) dispensing fee from £1.04 to 65p retrospectively effective from April, 2006. And that the adjustment would be made in February.

It also advised contractors that there would be no increase in the dispensing fee for 2006-07.

After taking legal advice, PCC instructed solicitors to write to the DHSSPS threatening legal action on the basis that its decisions were unlawful, unfair and that they had failed to deal with the issues appropriately.

After considering its options, the DHSSPS said that it would repay contractors the clawback instalment fee at the end of March, and has

### Pharmacist named local commissioning chief

Pharmacist Sheelin McKeagney has been appointed chairman of Northern Ireland's south area local commissioning group.

The former PCC chairman will front one of seven groups responsible for commissioning local healthcare from March 2008.

Mr McKeagney predicted a positive future for pharmacists under the changes.

He said: "Pharmacy will get a fair crack of the whip due to the very broad range of professions involved in the LCG committee, which is really a development of LHSCGs which ran here in Northern Ireland for the past few years.

"Pharmacists really punched well above their weight on the LHSCGs and demonstrated the added value



Sheelin McKeagney: "Pharmacy will get a fair crack of the whip"

that multidisciplinary working can bring to the table."

Each LHG comprises one pharmacist representative, with two places yet to be filled as C+D went to press.

of the new pharmacy contract".

- A survey of drug use in Ireland and Northern Ireland has revealed that over one fifth of the adult population in Northern Ireland had not used any drugs (legal or illegal) in the last month.

Further information is available at: [http://www.dhsspsni.gov.uk/index/stats\\_research/stats-pubs.htm](http://www.dhsspsni.gov.uk/index/stats_research/stats-pubs.htm)



Eying up the job: youngsters aged six to seven years from Ermington Primary School in Ivybridge, Devon, took a closer look at pharmacy during a visit to the headquarters of Park Pharmacy Trust in Plymouth. The children had practical experience of making Victorian toothpaste, crimping the end of the toothpaste tube and making a carton to fit the tube

## Robo drug dispenser hits high street

**Practice** Digital system photographs patients for ID

**Lloydspharmacy** has rolled out an automated methadone dispensing system in eight pharmacies.

The Methasoft system uses digital photography to ID patients and has been on trial at the company's Hanley, Stoke-on-Trent pharmacy for the past year.

Methasoft measures doses of methadone via an integrated pump, dispenses and labels both supervised and dispensed doses, according to Lloydspharmacy. The system also keeps a record of medicine dispensed to individual patients, and captures a signature on the CD register on collection.

Lloyds estimates that Methasoft will save hundreds of staff hours. **AC**

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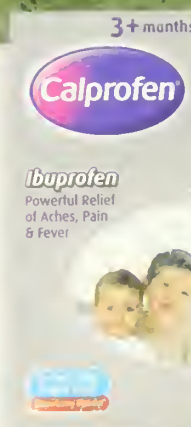


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Contains ibuprofen

Name  
Mark Green

Pharmacy  
Weldricks Pharmacy, Skellow, Doncaster

What has he done?

**Implemented a minor ailments scheme**

#### What have you set up?

I ran the initial pilot for the PCT minor ailments scheme, which was designed to ease the pressure on GP appointments. The full service is evidence-based, incorporating PGDs so that prescription items can be supplied to patients without the need for referral.

Initially it was run in one pharmacy and with one GP practice. I have since been helping to roll it out across the whole PCT. Patients can self-refer or be referred by their GP. The latter requires reception staff to triage patients and identify those who could be treated under the minor ailments scheme.

This has been a key to its overwhelming success.

Patients who would have had to wait for a non-urgent appointment with a GP can be seen by a pharmacist, assessed, given advice and treatment within a few minutes.

#### Were there difficulties?

Initially I worked closely with the practice manager to ensure that everyone understood their roles and responsibilities within the scheme. This was difficult on two fronts. First, it was all new and as always there was opposition to change. Second, there was a perception that it would mean lots of extra work with little benefit. I reassured reception and admin staff, the GPs and practice manager and maintained daily contact throughout the first few weeks. This allowed me to deal with practical problems until everyone was familiar with the administration. Although time-consuming, it significantly strengthened communication between the practice and the pharmacy.

Uptake was initially slow and required us to tell patients about the minor ailments service. We also produced counter leaflets, but word of mouth has been the best publicity.

#### How have the patients and GPs reacted?

When the scheme was rolled out across the PCT, I had moved to work in a neighbouring village and again had communication difficulties with the local GP practice. Not being in close proximity meant I couldn't easily visit the practice. However, I attended a target training session at the practice and was able to explain how the scheme worked to a mixed audience. Once everyone understood the benefits, they couldn't wait to get started. Even the GP who was set against the idea could see the logic of moving the treatment of minor ailments to the pharmacy.

# Pharmacy Champions

## Pharmacists leading the way

Pharmacy  
Champions



I've improved my knowledge by working closely with the GPs on the scheme, and asking their advice has strengthened our working relationship. Likewise they come to me with prescribing queries, availability problems and other patient compliance issues. The patients appreciate having an extra service, particularly as they can see a pharmacist at short notice and without an appointment. They also like receiving the patient information sheets, which give more details about their condition and medicines.

#### Do you have any advice for others wishing to set up new services?

Be proactive in finding out what new services your PCT would like to develop. Communication – with the PCT, GP practice and patients – is also very important.

#### Why do you think you have been successful?

We identified an area in which there wasn't a service. Patients are used to going into the

pharmacy for the treatment of self-limiting conditions and it wasn't difficult for them to accept that a pharmacist is well placed to treat their minor ailments. We have created a win-win situation for us, the GPs and the patients.

#### Has offering the new service given you greater job satisfaction?

It's made my work more varied and interesting, as well as saving time and duplication of effort.



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# Comment from the editor

## Ministers must encourage sustained innovation



**If ever there was a clear statement of intent** from the government on the future direction of community pharmacy, then surely it was contained in the consultations on controlled drugs this week.

That the government is seeking views on whether pharmacists should be allowed to prescribe some Schedule 2 drugs in the management of drug addiction shows just how far pharmacists have come in a few short years.

Since the turn of the century, community pharmacists across the UK have gained prescribing

rights, been recognised as practitioners who can develop special interests, and have as part of their new contracts (with Scotland in particular) taken on increased responsibility for the care of their patients.

As a profession, it seems we are a million miles away from when we had to check every change – however minor – with the prescriber.

And those who have been on the pharmacy dinner circuit over the past week will have heard former pharmacy minister Andy Burnham backing pharmacy with his bullish comments about the sector's future role in helping the NHS cope with the increased demands of an ageing population.

But – and this is an important but – pharmacists are running a business and without some secure foundation what incentive is there to invest in service delivery? So as the Galbraith review enters its final stages, ministers must consider how the changes, if any, that they plan to make will

encourage sustained innovation in pharmaceutical services from a diverse network of pharmacies.

### Pfizer, wholesalers, and pharmacists

The future of pharmaceutical wholesaling was spelt out by PSNC chief executive Sue Sharpe this week.

"Substantial and adverse changes in the distribution system during the next 12 months" could mean that the full-line wholesale system could come "under real threat", she told contractors.

With several manufacturers having stated their intent to examine their distribution arrangements following Pfizer's new deal, it seems that Ms Sharpe's fears may well hold true.

With full-liners contributing so much more than just twice daily deliveries, community pharmacists need to consider how a possible future without full-liners or even twice a day deliveries will impact on the service they provide.

## Andy Burnham has been backing pharmacy with his bullish comments

## Your views

### We must make remote supervision a remote possibility

**Mark Koziol is unconvinced of the desirability of operating a pharmacy without a pharmacist present**



**Officers of the Pharmacists' Defence Association (PDA)** recently attended a number of informal Department of Health consultations on the Health Act (which contains the remote supervision idea) and were encouraged to learn that the Department has decided not to pursue the idea of remote supervision

at this stage, concentrating instead on implementing the concept of the responsible pharmacist. However, there is still talk about the possibility of deploying remote supervision at some later stage.

The stated position of the PDA on remote supervision (the plan to operate a pharmacy in the absence of a pharmacist) is that it constitutes a significant threat to public safety. When we lobby MPs and other key decision makers, it never takes very long for them to become alarmed at the prospect of what is really being proposed.

When we surveyed pharmacists on the subject, an overwhelming majority saw this proposal as nothing more than a cost cutting exercise that would benefit the government and some large employers, rather than patients.

The basis of the remote supervision proposal is that the presence of a pharmacist is to a greater extent replaced by new standard operating procedures (SOPs), which are supposed to ensure that patient

safety is maintained. Research exists on the use of SOPs in mainland European pharmacies, which shows that they are generally not adhered to.

However, any experienced pharmacist will know that a community pharmacy that runs without the presence of a pharmacist will not be as safe for a patient as one that does. These factors support the concern that allowing a pharmacy to operate in the absence of a pharmacist would constitute a risk to the public.

As many pharmacists will know, the PDA has campaigned and continues to campaign to ensure that remote supervision becomes no more than a far distant prospect.

At our recent annual conference, we announced that in the event that remote supervision was to be actively pursued, we would be organising a significant publicity campaign to bring the unacceptable consequences of these proposals to the attention of the government and the public. This would involve national advertising

and other forms of public awareness activity. Early indications are that pharmacists throughout the country would be prepared to actively support this initiative.

We must not allow these flawed proposals to proceed, because they represent a danger the public. We ask the leaders of our profession to ensure that they do not inadvertently allow patient safety to be compromised by acquiescing on this important issue.

**Mark Koziol is chairman of the Pharmacists' Defence Association**

## We must not allow these flawed proposals to proceed

# Xrayser

Topical Reflections

## The biggest thing since penicillin



I generally retain a healthy scepticism for 'non-conventional' treatments and I'm outspoken in calling a quack a quack. But if evidence comes to light I'm delighted to welcome old wives' remedies into my science-based fold. I love to recommend, and advise on, fish oils, antioxidants and St John's wort.

But a recent visit from a sales rep left me wondering if I'd been missing a very important trick. I see fewer reps than ever before but this one was from a 'friendly' company and the shop was unusually quiet. He sold me, there and then, a year's supply of a new herbal remedy that looks set to be the biggest thing since cod liver oil. In fact, I'd even go as far as to say that this new preparation could have a bigger impact on our health than penicillin.

The rep had evidence from randomised controlled trials and testimonials from eminent medics and pharmacologists. He had everything that's usually lacking

when I'm not convinced of the worth of a new product.

Polfar oil has been used by South American tribesmen for centuries, topically and orally, for everything from analgesia to aphrodisia but western medicine has never been able to test the oil effectively because it is so unstable. But a new technique has extended the half life of the active ingredients, enabling clinical trials in the UK.

Active ingredients of the oil have been isolated and presented in a tablet form that has convincing evidence for analgesic, antibiotic, antidepressant and anti-impotence properties.

And it's cheap. The manufacturers have been unable to patent the active ingredient so the market will soon be swamped with generic competitors. But they believe that their 'first to market' advantage will be big enough to keep shareholders happy for years.

It's guaranteed to sell out. And it's on special offer for one day only, April 1.

## Less smoke, more puff

**Gordon Brown has been accused** of using smoke and mirrors to make last week's budget speech appear better than it actually was. His announcement of a tax cut on NRT from 17.5 to 5 per cent (C+D, March 24, p4) was about cutting down on smoke but not about tackling the leading preventable cause of death.

The chancellor's decision to cut VAT on NRT on July 1 is welcome. But why not make NRT permanently tax-free? A man as shrewd as Mr Brown must surely see every penny lost in tax here is made up for in pounds' worth of savings to the NHS.

The summer smoking ban will encourage some smokers to quit. However, there will be millions who aren't persuaded but may change their mind at a later date.

It makes no sense that the government is happy to pay for NRT on prescription, and to treat smoking related illness, yet reluctant to encourage patients to purchase their own preventative medicine.

A lack of PCT funding for local smoking cessation services (C+D, March 17, p5) is further evidence of this double standard.



Black  
Bag

## White coats on the line

### If there is one thing

government really hates it is white coats walking the walk on the white line. Marching doctors are to politicians what practice-based commissioning is to pharmacists. Both are seen as a threat to survival.

On the junior doctor march there was a healthy mixture of consultants, GPs and those doctors who felt their training was in danger. After pumping in cash to increase NHS doctor numbers, the government suddenly found the money had run out.

This was blamed on GPs who had the temerity to actually reach the targets set in their contract. Nothing new here. Kenneth Clarke, when Tory health minister, once said: "Whenever I mention reform all I can hear is GPs reaching for their wallets."

Meanwhile, a central computer system costing more than Cuba's GNP has yet to crunch any numbers. Having health professionals out on the streets is

Marching doctors are to politicians what practice-based commissioning is to pharmacists. Both are seen as a threat to survival

never a good sign, not least because you do tend to wonder who is looking after the shop. In Ireland during the 1980s all the junior doctors downed stethoscopes and headed for O'Connell Street.

During a medical strike in Israel deaths declined, rising on return to work. Not letting fact get in the way of a good story, the media used this to beat medics around the head and neck, ignoring the need for death certificates to be signed by a doctor.

Mind you, I do hope the junior doctors get their white coats washed before picking up stethoscopes. White lines can be very mucky in London.

**Dr Ian Banks is a GP practising in Northern Ireland**

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of external heat. Observe elderly patients carefully for signs of toxicity and reduce dose if necessary. Non epileptic (myoclonic) reactions can occur. Caution in patients with myasthenia gravis. Dispose of used patches according to the SPC. Safety in pregnancy not established, do not use unless clearly necessary. Do not use during labour and delivery. Discontinue Matrifen for at least 72 hours before breast-feeding. Affects ability to drive and use machines. **Interactions:** Barbituric acid derivatives, CNS depressants, including opioids, anxiolytics and tranquilizers, hypnotics, general anaesthetics, phenothiazines, skeletal muscle relaxants, sedating antihistamines and alcohol. MAO-inhibitors. P<sub>1</sub>tonavir, pentazocine or buprenorphine. **Side-effects:** Most serious side-effect: respiratory depression. Very common (over 10%): somnolence, drowsiness, headache, nausea, vomiting, constipation, sweating, pruritus. Common (1-10%): sedation, confusion, depression, anxiety, nervousness, hallucinations, lowered appetite, xerostomia, dyspepsia, skin reaction at the application site. **Package quantities and price:** 5 patches in 5 strengths: 12 micrograms/hour: £18.85 25 micrograms/hour: £26.94 50 micrograms/hour: £50.32 75 micrograms/hour: £70.15 100 micrograms/hour: £86.46

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## Your views

### New college must be voluntary

**The main problem with the Royal Pharmaceutical Society** has been the fact it has always been pulled two ways by its two main functions, and its total complacency about its unassailable position within the profession.

The college should represent the profession and, like the BMA or medical college, should have to justify its existence. This is what is terrifying the RPSGB. For years it has simply done what it wants, without listening to members with the knowledge that membership was mandatory and it held the membership captive. Just look at the voting figures in Society elections to see how enthused the membership was about the current setup.

During a management training course in Morpeth in 2001, I and more than 40 other senior pharmacists wrote an open letter to the Society advocating splitting the

two roles of the Society and creating two separate bodies. Guess what, it never got published, simply because it did not follow the party line coming from Lambeth. Fortunately the government chose to ignore the bleats from the Society and what we all hoped would happen is finally going to take place.

If the Society becomes the core of the new college, then other organisations including the UKCPA, College of Pharmacy practice, Guild of Healthcare Pharmacist, NPA etc should all be intimately involved. Left to the Lambeth crowd, we will simply end up with the same lifeless organisation we have now.

**Ian Wright MRPharmS**  
Lynebank Hospital  
Dunfermline

Do you have a view you'd like to share? Email [haveyoursay@cmpmedica.com](mailto:haveyoursay@cmpmedica.com)

## Support for the pharmacist

**It was good to read that Xrayser** "welcomed" our public health support material (C+D, March 10, p15) and even better that he'd actually read it!

However, we would like to pick him up on a few points:

- "My staff and I can decide when advice is appropriate" – well maybe – but actually you are required to give brief healthy lifestyle advice to anyone presenting with a prescription who has diabetes, CHD, high blood pressure, smokes or is overweight. This is not optional.
- This brief advice is expected to take "up to three minutes".
- You will be assessed on how well you are carrying out this brief

advice by your PCT – so it makes sense to use the support resources. However, if Xrayser and his staff are already providing brief advice as required then they will find the resources useful for training new staff and locums.

- Finally, these resources are not about 'beating you with a stick'. They have been produced to help you and your staff give patients reliable, impartial and up-to-date public health advice. And by doing this well pharmacists will not only help their patients live healthier lives but also show the true worth of the pharmacy profession.

**Veronica Wray, communications consultant, PharmacyHealthLink**

## Xrayser wrong

**Xrayser is always a good read but I must correct a statement** (C+D, March 10, p15).

The Medicines Act does not require "P medicines to be kept out of patients' reach". I was responsible for Care Chemists for nine years before retirement and all of our medicines including P medicines were self-service. No complaint was ever made.

**David Sharpe, OBE, FRPharmS**

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Please include your name, job title if appropriate, your address and a contact number where we can reach you should we need to discuss the content of your letter.

Letters may be edited for length and/or content.

# C+D Clinical

## Dry mouth: how to treat it

Dry mouth is an under-recognised condition with significant physical and psychological consequences, and a potential adverse effect on medicines compliance

### Key points

- Xerostomia or dry mouth is characterised by a lack of saliva but other symptoms are prevalent such as swallowing problems, coughing and sore gums.
- The main cause of xerostomia is medication, particularly ongoing prescription medicines.
- Almost 1.5 million people in the UK suffer from dry mouth as a result of prescribed medicines.
- Although artificial saliva products and systemic pilocarpine are the main treatments, most patients rely on self-help measures, such as sipping water or chewing gum.
- Dry mouth may have an impact on medicines compliance and therefore is an important consideration in MURs.
- The pharmacist is ideally placed to offer advice on management approaches and on compliance with medicines that cause dry mouth.

*"It was the doctor's comment that Jean's blood pressure seemed a bit high that started it. After all, she was pushing 60 – wasn't that normal? It took several different medicines to bring it down to a level her doctor was happy with. The only trouble was she was having difficulty swallowing the tablets as her mouth was quite dry. In fact, she was conscious of having a dry mouth night and day, and was starting to get suspicious that it might be caused by her blood pressure tablets. Despite this, it seemed too trivial a problem to raise with the doctor, so she would just have to deal with it herself. Maybe she wouldn't need to take her blood pressure tablets for long?"*

### Marianne Mac Donald

Xerostomia, or dry mouth, is often not perceived by sufferers and healthcare professionals as a real complaint, yet sleep disruption, oral infections and dental problems are common sequelae. Jean is

### Reflect

Without looking anything up, can you name 10 prescription medicines that cause dry mouth? Do you ever ask patients taking these medicines if they are experiencing dry mouth problems? What action would you recommend?

### Plan

If you feel you need to know more about xerostomia, this article describes the adverse effects, causes and treatment.

Prescribed medicines are estimated to cause dry mouth in 1.5 million people in the UK



Photo: Steve Gossmeisser/Science Photo Library



This article can help in the following CPD competencies: C1a, C1c, C3a, G1a. See [www.tinyurl.com/194zu](http://www.tinyurl.com/194zu)



typical of most dry mouth sufferers who experience the problem as a side effect of prescribed medication.

As this can have an impact on medication compliance it is clear that the pharmacist – particularly in this era of medicines use reviews and independent prescribing – could be in the vanguard when it comes to providing advice on management options.

A new cosmetic product for dry mouth being promoted to the public (C+D, March 10, p25) could renew interest in this area.

The problem

Dry mouth is a common problem for people on ongoing medication and older people (over 55 years). Around 3 per cent of adults using medicines experience xerostomia – almost 1.5 million people in the UK alone.<sup>1</sup>

Of these sufferers, four out of five experience dry mouth symptoms at least twice a week, with half suffering every day. A similar percentage claim their symptoms are quite or extremely severe.<sup>1</sup>

Symptoms are not always limited to dry mouth. They can also include:

- cracked, painful lips
- insufficient saliva for chewing and swallowing
- burning tongue
- 'frothy' saliva
- halitosis
- sleep disruption because of having to wake to drink water
- coughing, often during sleep
- sense of choking
- difficulty speaking, and
- difficulty tasting food.

Long-term xerostomia sufferers can develop dental caries and gum disease as the lack of saliva in the mouth results in a failure to remove damaging bacteria from the oral cavities. Similarly, this lack of control over oral bacteria can lead to oral candidiasis (thrush).

In addition to the physical impact, sufferers may also bear a psychological burden such as embarrassment over halitosis or difficulties in speaking (see Box 1 above right).

The causes

Xerostomia is characterised by a lack of saliva in the mouth. Most people experience it on

Box 1: What sufferers say<sup>1</sup>

"Sometimes it causes embarrassment when you're meeting people or talking to people, because you feel that you can't speak to people as you would normally like to speak to them. You have to stop and sort of hesitate and carry on again."

"At night you wake up and your mouth is completely dry and then you start coughing."

"I'm taking a tablet to relax me at night and to make me go to sleep and I can't go to sleep because I'm so dry, I'm drinking all the time so I'm catnapping at night."

Table 1: Top 20 most commonly prescribed medicines that cause dry mouth

| Drug                | Category                                                       |
|---------------------|----------------------------------------------------------------|
| Amitriptyline       | Tricyclic antidepressant                                       |
| Amlodipine          | Calcium channel blocker                                        |
| Chloramphenicol     | Antibacterial                                                  |
| Doxazosin           | Alpha-adrenoceptor blocking drug                               |
| Enalapril           | Angiotensin-converting enzyme inhibitor                        |
| Esomeprazole        | Proton pump inhibitor                                          |
| Gabapentin          | Antiepileptic                                                  |
| Insulin             | Diabetes control                                               |
| Ipratropium bromide | Antimuscarinic bronchodilator                                  |
| Lansoprazole        | Proton pump inhibitor                                          |
| Lisinopril          | Angiotensin-converting enzyme inhibitor                        |
| Morphine            | Opioid analgesic                                               |
| Nicotine            | Nicotine replacement therapy                                   |
| Omeprazole          | Proton pump inhibitor                                          |
| Pantoprazole        | Proton pump inhibitor                                          |
| Ramipril            | Angiotensin-converting enzyme inhibitor                        |
| Rabeprazole         | Proton pump inhibitor                                          |
| Tamsulosin          | Alpha-blocker                                                  |
| Venlafaxine         | Serotonin and noradrenaline re-uptake inhibitor antidepressant |
| Zopiclone           | Hypnotic                                                       |

Source: MAT UK Data October 2006.

This is not an exhaustive list – refer to usual reference sources (eg BNF) for information.

waking, as saliva production and flow are reduced during sleep. For others it is a continuous problem, with the salivary glands failing to provide adequate levels of saliva.

**Medication** The most common reason for this reduction is medication, with around 75 per cent of cases due to an adverse drug effect on the salivary glands. The medicines most

commonly implicated are those that exert antimuscarinic effects, such as some antidepressants, anti-epileptics and cardiovascular drugs.<sup>2</sup> A list of the most common culprits is shown in Table 1.

While the vast majority of these drugs are prescription only, several are available over the counter and pharmacists should consider OTC medicine use during patient questioning.

However, xerostomia is more of a problem with ongoing medications than with those for short-term use, such as OTC medicines. In the UK, about 120 million prescription items a year cause dry mouth as a side effect.<sup>3</sup>

**Other causes** There are, however, other causes of xerostomia:

- Auto-immune diseases, such as rheumatoid arthritis and systemic lupus erythematosus. These lead to a related condition, Sjögren's syndrome, which affects various parts of the body, including the salivary glands, resulting in dry mouth.
- Radiotherapy of the head and neck, which damages the salivary glands.
- Depression, diabetes, and stress and anxiety.

## The treatment

Treatment of dry mouth should initially focus on removing the cause where possible. For example, if relevant, stress relieving techniques should be considered. In drug-induced xerostomia, consider suggesting to the GP the possibility of altering medication to one that does not cause dry mouth or reducing dosage, if appropriate, to minimise this adverse effect.

**Artificial saliva** The main treatment currently available is artificial saliva products, but these

are used by fewer than 10 per cent of xerostomia sufferers.<sup>2</sup> Artificial salivas mimic the composition of saliva and are applied in the form of sprays, tablets, pastilles or liquids. According to the British National Formulary, a properly balanced product should be pH neutral and contain electrolytes, including fluoride, similar to the composition of saliva.<sup>2</sup> Products that are slightly acidic may not be appropriate in treating dry mouth.<sup>2</sup>

If recommending, check the dosage as this can vary from "as required" to "up to four times daily to as required". If supplying against a prescription, some are approved by the ACBS only for the treatment of specific dry mouth conditions, such as xerostomia resulting from radiotherapy.

Refer to the product licence for each product's indications and the Drug Tariff for permitted indications under the ACBS scheme. Where a product is not permitted for NHS prescription, the dry mouth sufferer can still purchase it OTC.

**Saliva stimulants** Pilocarpine tablets are available on prescription for patients with dry mouth following irradiation for head and neck cancer, and dry mouth and dry eyes in Sjögren's syndrome. It is effective only in those who have some salivary gland function.

Advise patients using these products post-radiation that the full therapeutic effect will not be apparent for four to eight weeks.

Systemic pilocarpine should be avoided or used with caution in certain patients. In addition, it causes a number of side effects including headache, flu-like symptoms, increased urinary frequency, sweating,

gastrointestinal disturbances, hypertension and dizziness.

Malic acid promotes saliva flow and is available in non-prescription saliva stimulants. New to the market is a non-licensed lozenge combining malic acid with fluoride to help prevent the dental caries common in those with xerostomia. The product can be taken as required and, for best results, allowed to dissolve slowly in the mouth. It can be recommended for xerostomia of any cause but should not be used in children under 12 years, pregnant or breastfeeding women or patients with no or non-functioning salivary glands (see references at end).

**Self-treatment** Pharmacists will discover, however, that patients will have developed their own means of management, with most sufferers reliant on self-treatment approaches such as sipping water, sucking ice cubes or sweets or chewing gum.

Although these are effective measures and should form part of the additional advice provided by the pharmacist, their benefits are short-term. Research shows one in six sufferers adopt such tactics more than 10 times daily.<sup>2</sup>

## Identifying xerostomia

Many xerostomia sufferers may not always associate their problem with their medication, or be aware that there are treatments and self-help measures available. As such, the pharmacist is ideally placed to offer advice and guidance, in particular as part of the MUR process:

- Ask patients taking medicines identified as causing dry mouth if they are experiencing any symptoms.
- In cases where compliance is an issue, determine whether dry mouth and difficulty in swallowing is an underlying reason for avoiding medication.
- Determine if there is any oral candidiasis as a result of xerostomia and treat appropriately.
- Advise long-term sufferers to consult their dentist as there may be problems with dental caries.

In addition, medicines counter assistants can be alerted that several OTC products can also cause xerostomia, providing the opportunity for counselling and appropriate recommendation. Sufferers may also be looking for products for their dry mouth in other areas in the pharmacy, such as mouthwashes and mouth ulcer products. This provides another opportunity for intervention.

Marianne Mac Donald, MRPharmS, is a pharmacist and medical writer.

## References:

1. IPSOS MORI research for Actavis. April and May 2006.
2. British National Formulary. Edition 52. 12.3.5 Treatment of dry mouth.
3. MAT UK Data October 2006.

## Continuing Professional Development



### Act

- Read the British National Formulary section on preparations for the treatment of dry mouth.
- Make a list of what is prescribable on the NHS under the ACBS scheme and for what indications.
- Do your own research into medicines causing dry mouth and expand the list of culprits in Table 1.
- Ask, say, the next 20 patients who are taking the medicines most likely to cause dry mouth whether they are having problems swallowing medication. Record what advice you gave and whether it worked.
- Incorporate such questions in your MURs where appropriate.
- Make a list of non-prescription medicines likely to cause dry mouth and show it to your medicines counter assistants.
- Make sure your staff know what products can be sold for the relief of dry mouth, and direct them to the oralcare feature in Over the Counter magazine (March 17, p14) to learn about the new product for dry mouth.
- Have you any patients who might have xerostomia because of the other reasons listed in the article? Make a note to ask them about any problems the next time they come in, and record the advice you give.

### Evaluate

Did the above exercise identify people with xerostomia who did not realise their medications were causing the problem? What advice did you give? Did it help? If not, what are you going to do next?

## A Practical Approach...



It is late spring and the weather has been hot and sunny for the last week. Pharmacist David Spencer is working in his office at the Update Pharmacy when Claudine, one of the medicines sales assistants, knocks on the door.

"Come in, Claudine. What is it?" says David. "I'm very sorry Mr Spencer," Claudine replies, "but I think I'm going to have to go home. My hayfever's really terrible. It's worse than ever this year."

"Yes," David says, "I can see your eyes are very red and watery. But you're taking desloratidine tablets, aren't you?"

"Yes, the obstetrician prescribed them for me when I went for my antenatal appointment last week, but they don't seem to be helping at all. And it's not just my eyes, although they are terribly itchy. My nose is completely blocked, and breathing through my mouth is making that very dry. It's really miserable. I was wondering whether you could suggest something that might help, but of course I don't want to use anything that might harm the baby."

"Can you remind me, how many weeks pregnant are you?" asks David.

"About 18."

## Questions

1. What is the general situation regarding the OTC supply of hayfever treatments in pregnancy?
2. Is there anything effective that David could recommend?

Answers →

This article can help in the following CPD competencies: C1a, C1f, G1a, G1c. See [www.tinyurl.com/194zu](http://www.tinyurl.com/194zu)

## Viral cause found in many kids given antibiotics

Most children with a cough and fever for whom GPs would consider prescribing an antibiotic have a detectable viral infection, say UK researchers.

An analysis of children prescribed antibiotics for an infection that was "more than a simple cough or cold" showed the treatment did not alter the course of their illness.

The researchers from Oxford University said the findings reinforced the argument that respiratory infections in the community are predominantly viral and, in the absence of respiratory difficulties requiring admission, are self-limiting and do not require antibiotics.

Overall, the study looked at 425 children

aged six months to 12 years in whom GPs had considered their illness severe enough to prescribe an antibiotic.

A viral cause of infection was detected in 77 per cent of the children. One third of children were prescribed an antibiotic but this made no difference to the rate of recovery.

Vaccinating children against influenza could help to reduce inappropriate antibiotic prescribing, the researchers added.

### For more information:

Arch Dis Child, published online, March 16 2007

## Aspirin reduces overall mortality

Women who take low to moderate doses of aspirin have a reduced risk of death from any cause, according to US researchers.

Analysis of the association between aspirin use and death in 79,439 female nurses followed from 1980 until 2004 found that those who reported using aspirin currently had a 25 per cent lower risk of death from any cause than women who never used aspirin regularly.

The association was stronger for death from cardiovascular disease with a 38 per cent lower risk in aspirin than deaths from cancer, which had a 12 per cent lower risk. Also, a significant cardiovascular benefit was evident at five years of treatment, and cancer benefits were seen at 10 years.

### For more information:

Arch Intern Med 2007; 167: 562-72

### In brief

**The use of antiviral** drugs for the treatment or prevention of seasonal influenza is no longer indicated, the DH says. Influenza reports have fallen below the level at which antivirals should be used. [www.dh.gov.uk](http://www.dh.gov.uk)

**Scientists** at the University of Manchester say injections of tiny gel particles could provide an alternative to major surgery for the treatment of chronic lower back pain. [www.manchester.ac.uk](http://www.manchester.ac.uk)

### Help shape C+D's clinical content

We'd like **you** to be part of C+D's new Clinical Advisory Panel, which will help shape our clinical content and ensure it meets the needs of pharmacists. Email clinical editor Gavin Atkin at [gmatkin@cmpmedica.com](mailto:gmatkin@cmpmedica.com) today.

### A Practical Approach... this week's answers

foetal development, but the manufacturer recommends that it should be used in pregnancy only if there is a clear need. David could recommend sodium cromoglicate eye drops and possibly the nasal spray, although the latter is a prophylactic treatment and could take some time to take effect once hayfever symptoms have occurred. As Claudine is already under medical supervision David should consult her obstetrician or GP first, and if they are willing to prescribe it Claudine would then also get the medicines free. To help with the nasal congestion, David could suggest that Claudine try steam inhalations, using menthol or other suitable inhalants.

1. Although antihistamines have not been shown to be teratogenic in animal studies, all systemic doses of corticosteroids in animals have been found to retard foetal growth and cause foetal abnormalities such as cleft palate. It is therefore assumed that there could be a very small risk in humans, and even though corticosteroid hayfever preparations are only used locally in the nose and at small doses, manufacure and fluticasone should only be supplied to pregnant women on medical advice. Cumulative experience with sodium cromoglicate suggests that it has no effect on

# SALIVATION

TABLETS FOR DRY MOUTHS

FORMULATED FOR  
ORAL MOUTH SUFFERERS

HELPS TO STIMULATE  
SALIVA FLOW

hydro<sup>tab</sup>

NEW

25 TABLETS

## FOR DRY MOUTHS

120 million prescriptions a year cause dry mouth. That's a lot of people. And, now there's something you can do about it, a massive medicine usage review opportunity for your pharmacy.

hydro<sup>tab</sup> is a sugar-free tablet that helps stimulate saliva flow to relieve dry mouth. It's supported with a £1 million launch campaign and, in research, 73% of respondents said they'd buy it if you recommended it. So go ahead, save their day.

hydro<sup>tab</sup>

Formulated to make your mouth water

 **actavis**  
creating value in pharmaceuticals

## Clinical news

## Artery hardening in smokers is reversible

After 10 years without tobacco, smokers get back to the lower level of arterial stiffness of a non-smoker, say Irish researchers.

However, the recovery is gradual: arterial pulse wave analysis showed ex-smokers of only one year still had significantly higher stiffness measurements compared with non-smokers.

Previous research has shown that just one cigarette can begin the process of arterial hardening, increasing the risk of cardiovascular events.

**For more information:**

Hypertension published March 19, 2007



Photo: CDC/Dr Edwin P Ewing Jr

## Concerns over OTC simvastatin?

Pharmacists are able to confidently provide over the counter simvastatin, but many have concerns about the scheme, a large survey suggests.

Answers from more than 1,000 community pharmacists showed almost 94 per cent had received training to provide simvastatin and could make an appropriate risk assessment.

But many raised concerns that the cost was often prohibitive to those who really needed it, that there was no evidence the 10mg dose would have any effect on cholesterol, and that

many 'worried well' patients purchasing the drug were among the least likely to benefit.

Study leader Dr Derek Stewart, senior lecturer in pharmacy at Robert Gordon University in Aberdeen, said the industry needed to be clearer on what products were most appropriate for patients.

**For more information:**

Pharm World Sci, published online, March 15, 2007

## Clarification on first choice for epilepsy

Lamotrigine should be the drug of first choice for patients with partial epilepsy, while valproate should be preferred for generalised and unclassifiable epilepsy, results from a large UK trial suggest.

There has been a steady rise in prescribing of newer anti-epileptic drugs, but the evidence on these versus older treatments has been unclear.

In one arm of the SANAD (Standard and New Antiepileptic Drugs) study, 1,721 patients with new onset partial seizures were treated with carbamazepine, gabapentin, lamotrigine, oxcarbazepine or topiramate.

Lamotrigine emerged as significantly better

for time to treatment failure than either carbamazepine, or the newer drugs gabapentin and topiramate.

In the other arm of the study, valproate was compared with lamotrigine or topiramate in 716 patients with generalised onset seizures.

Valproate was significantly more effective than topiramate for treatment failure, and significantly more effective than lamotrigine for 12-month remission.

**For more information:**

Lancet 2007; 369: 1000-26

## Nice drugs limited in primary care

One in four GPs believes prescribing of Nice approved medicines is inhibited in some way, an online survey has shown.

Less than half of the 530 GPs questioned were aware of the legal requirement on the NHS to provide funding for medicines recommended by Nice.

Two-thirds said they were bound by prescribing incentive schemes, which could earn up to £35,000, the survey revealed.

**For more information:**

www.onmedica.com

## In brief

**Results from the METEOR trial** of rosuvastatin have disappointed many observers. Presented at the American College of Cardiology Scientific Session, the research showed that the treatment halted progression of atherosclerosis, but did not make it regress, as hoped.

**Rates of TB** are continuing to rise in the UK, figures from the Health Protection Agency show. In England, Wales and Northern Ireland the number of new cases rose by 2 per cent between 2005 and 2006 from 8,008 to 8,171 diagnoses.

**The European Medicines Agency** has added a warning that signs of strange behaviour in patients treated with Tamiflu should be notified to the relevant health professional. The warning follows reports of convulsions, depressed levels of consciousness, abnormal behaviour and hallucinations in patients in Japan.

**Dovonex calcipotriol ointment** is to be withdrawn on April 16, Leo Pharma has announced. The organisation made the decision based on the commercial viability of the product, and advises that existing stocks can be dispensed with confidence.

**Risedronate may improve** bone health in people who lack exercise due to Parkinson's disease, say Japanese researchers. A two-year study of 242 elderly men with Parkinson's disease found those given the bisphosphonate and vitamin D<sub>2</sub> were three times less likely to sustain a hip fracture. *Neurology*; 2007 68: 911-15

## Testosterone for women

Intrinsa is a testosterone patch for women distressed by low sexual desire following hysterectomy and bilateral oophorectomy.

As many as a million women in the UK have had their ovaries removed following conditions such as endometriosis, fibrosis and pelvic pain. Testosterone levels in this group typically fall by around 50 per cent, which leads to a loss of sexual desire in many patients.

In studies, treatment using the twice-weekly patch delivering 300mcg/24 hours testosterone was associated with significant improvements in both sexual desire and activity over six months. Side effects were mild and reversible, but few patients discontinued treatment.

The treatment should not be used by patients with suspected breast cancer or a history of the condition.

Intrinsa is provided by Procter and Gamble in packs containing eight patches at £24.50 each. The Pip code is 3274172.

# QuickStrip bolsters 4head

The 4head stick topical headache treatment has been joined on-shelf by a new hydro-gel format.

Said to provide immediate cooling relief from the pain of headaches and migraines, the 4head QuickStrip contains levomenthol to reinforce

the analgesic feeling of coldness, says Dendron. It can be applied to relax tense muscles in the head and neck and can be cut to size.

Each strip remains active for up to six hours and there is no need to refrigerate the product, says the company. As with the stick format, it can be used in combination with oral medication. For migraineurs, the QuickStrip is recommended for all stages of a migraine: pre- (aura), during and post-migraine.

Supporting the launch, press, TV and PR activity is planned and point of sale materials are available including giant cubes and shelf wobblers.



**Price: £4.99/8**  
**Pip code: 325-2962**

**Product info:**  
Dendron  
Tel: 01923 229251

## Timely message from Zovirax



Zovirax cold sore cream is to benefit from a £1 million advertising spend.

Beginning this week, the 'Think fast think Zovirax' TV creative, first shown last September, will be aired until May 6.

National press advertising in women's interest and health titles will reinforce the message until early July.

Both the TV and press ads feature

a woman using a photo mount in a 'now you see it, now you don't' gesture showing her coldsore disappearing fast. In the TV ad a spinning clock stresses the product's speed of action.

**Product info:**  
GlaxoSmithKline  
Tel: 0845 762 6637

## A brush with Sensodyne

The Sensodyne brand has been extended with the launch of the Pronamel toothbrush. Its introduction is part of GSK's stated aim of addressing the growing issue of tooth wear, particularly dental erosion.

The brush features gel pad technology with 3D flexibility and microfine rounded bristles, designed to provide gentle cleaning while protecting tooth enamel. It is targeted at health conscious consumers. Four colours are available.

Supporting the new brush, a 10-second tag will follow the existing Sensodyne Pronamel toothpaste ad.

**Product info:**  
GlaxoSmithKline  
Tel: 0845 762 6637



**Price: £2.99**

### Products in brief

#### Itching to know?

A new edition of Understanding Eczema has been published by Family Doctor Publications. Over 200 pages offer information on the different types of eczema, causes, treatments and FAQs.

Price: £4.74; Pip code: 326-8323  
Family Doctor Publications  
Tel: 01202 668330

## C+D's one minute interview with ...

### George Reeves, brand manager for Canesten thrush treatments

#### Who buys your product?

With three out of four women suffering at least one bout of thrush during their lifetime, some many more, the customer base is very broad.



#### Why stock Canesten thrush treatments?

This is a very large market and the value is very significant. Canesten is in the top 10 pharmacy brands in terms of value. It has a dominant market position with a share close to 80 per cent.

#### How can pharmacies sell more?

Educate yourself and your staff using the pharmacy training modules available from Bayer. If pharmacists and their staff can recognise the condition and give the best advice to customers they are more likely to complete a sale.

#### Are there any brand innovations in the pipeline? Or a dream innovation you'd like to see?

No, there's nothing I can talk about at the moment. But NPD has always been a strong driver of growth for Canesten. Advertising has destigmatised the condition. The most recent launch was the Oral and Cream Duo product which is now the market leader.

#### Who would be your ideal spokesperson?

We don't have a spokesperson. But it could be anybody who has suffered with thrush and used Canesten.

➤ **Interested in appearing in C+D's one minute brand manager interview? Contact Lesley Ribbens on 01732 377600 or email [lribbens@cmpmedica.com](mailto:lribbens@cmpmedica.com)**

# TIMELESS

OTC  
DIRECT  
Now reference for Generics and P.I.s

For quick and easy purchasing of Generics and P.I.s CALL **0800 169 2305**

# Hayfever has new opponent

Actavis is entering the OTC hayfever market with the launch of Pollenshield.

Containing 10mg cetirizine HCl, the product is said to be a non-drowsy antihistamine with few side effects or interactions. One tablet should be taken daily by sufferers over six years of age.

Commenting on the launch, Richard Hollies, OTC sales and marketing manager for Actavis, said: "There are currently 12 million hayfever sufferers in the UK and this figure is expected to rise. The hayfever market is worth £79.1 million and is growing at around 5 per cent on year.

"Pollenshield is one of our fighting



brands offering cost-effective alternatives with a healthy profit margin for pharmacists."

**Prices and Pip codes: £2.25/7, 324-4704; £4.25/30, 324-4696**

**Product info:**  
Actavis  
Tel: 01271 311200

# Bic's two for one activities offer

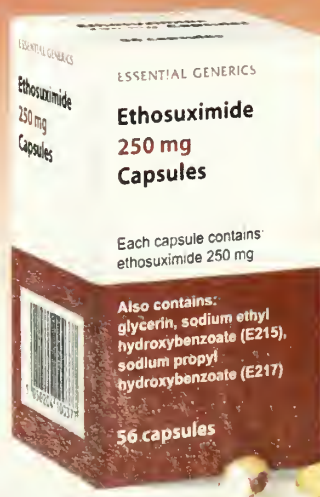
Bic is running an on-pack promotion on its Comfort 3 Advance triple blade male shaver. Consumers taking up the offer can try activities such as waterskiing or scuba diving.

**Product info:**  
Bic  
Tel: 01895 827100  
www.bicworld.com

## IMPORTANT ANNOUNCEMENT

### Ethosuximide 250mg Capsules

[Replacing Emeside 250mg capsules from April 2007]



**Now available**

Ethosuximide Capsules now available through mainline pharmaceutical wholesalers

Pip code 232-1032  
Prosper 053181  
Link ETH501E

**Indications:** For selective control of absence seizures (petit mal) even when complicated by grand mal; myoclonic seizures. **Legal Category:** POM. **Marketing Authorisation Holder:** Essential Generics, 7 Egham Business Village, Crabtree Road, Egham, Surrey TW20 8RB. Please consult the Summary of Product Characteristics before prescribing for side effects, precautions and contra-indications. **Date of preparation:** March 2007. PC 0005

For further information please contact:  
Essential Generics, 7 Egham Business Village, Crabtree Road, Egham, Surrey TW20 8RB, UK.

Adverse events should be reported to Essential Generics. Information about adverse event reporting can also be found at [www.yellowcard.gov.uk](http://www.yellowcard.gov.uk)

# GSK's gripping yarns with bite

**Speak, eat and smile with confidence**



Poligrip Ultra has begun a £1.1 million TV advertising campaign, scheduled to run until mid June.

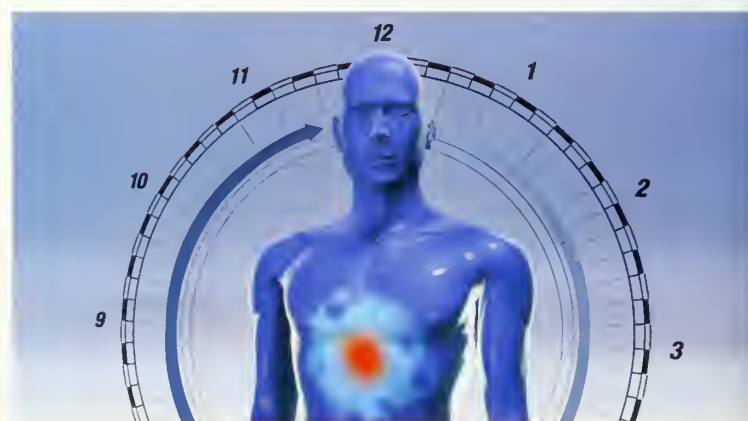
The creative takes the style of a testimonial – a new departure for the brand in the UK.

A character called Christopher explains the daily problems faced by

denture wearers and tells viewers of the difference Poligrip has made to his life.

**Product info:**  
GlaxoSmithKline  
Tel: 0845 762 6637

# Zantac's Blue Man returns

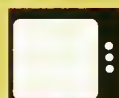


The Zantac 'Blue Man' makes his 2007 TV debut this week.

The ad explains how the symptoms of heartburn and indigestion can be relieved by Zantac 75 and the Relief

and Relief Dissolve variants.

**Product info:**  
GlaxoSmithKline  
Tel: 0845 762 6637



**Products advertised on TV next week**

**Deep Heat:** All areas except five  
**DulcoEase:** C4, GMTV, Sat  
**Gaviscon Double Action:** All areas  
**HemoClin:** GMTV, Sat  
**Just for Men:** All areas  
**Poligrip:** All areas  
**Zantac:** All areas  
**Zovirax:** All areas  
**PharmaSite for next week:** Zantac – Windows, Zantac – In-store, Zantac – Dispensary  
**Pharmacy channel:** Vega Nutritionals, elave, Complian, Ibuleve

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire



*New Care Stingose<sup>®</sup>*  
*The antidote to bites and stings from down under*  
*is now available over your counter*



**Why buy the same old story when you can now sell the antidote?** Care Stingose<sup>®</sup> Spray is the only antidote for bites and stings. Unlike most remedies which just relieve the symptoms, Care Stingose works on the cause as it neutralises the venom – so the sting goes. Care Stingose relieves the pain and reduces the effects of bites and stings from wasps, bees, mosquitos, nettles, jellyfish and stinging plants – which is why it became Australia's No.1 selling bites and stings treatment.

For more information please call 01484 848200 or contact your local sales representative.



— All the care you need. —

**Presentation:** Pump spray for topical application. **Contains:** Aluminium Sulphate 20% w/v, Sodium Lauryl Diethoxysulphate, Fragrance SLN 3004 and Purified Water. **Indications:** The antidote for stings and bites. Relieves pain and reduces the effects of stings and bites from insects, animals and plants. **Dosage and Administration:** Adults and Children: Spray immediately into the affected skin. Re-spray if necessary. **Contraindications:** There are no contra-indications to Stingose. Some individuals may have limited skin reaction of short duration, but these are rare. **Warnings and Precautions:** Stingose should not be applied to the eyes. The skin must not be pre-treated with methyl spirits or alcohol, as this will reduce the activity of Stingose. **Pregnancy and Lactation:** No effects known. **Side Effects:** None known. **Legal Category:** GSI. **Licence Number:** PL 13227 0001. **Pack Size:** 25ml. **Retail Price:** 25ml £3.99 inc VAT. **Trade Price per Single:** 25ml £1.88 ex VAT. **Licence Holder:** Westvale Ltd, 1 Park Place, Canary Wharf, London, E14 4HJ. **Manufacturer and Distributor:** Thornton & Ross Ltd, Linthwaite, Huddersfield, HD7 5QH. **Date of Preparation:** 12/03/07.

Thornton & Ross Limited, Linthwaite, Huddersfield, West Yorkshire HD7 5QH Telephone: 01484 842217. Care+ and the lozenge device are trademarks of Thornton & Ross Ltd



# Over to you

**Wesley Yin-Poole** reports from this year's LPC conference

With an expectant crowd in the grand surroundings of London's Royal Lancaster Hotel, PSNC outgoing chairman Barry Andrews opened proceedings at his final LPC Conference last week by heaping praise on pharmacists for embracing MURs.

How fitting, then, that as the conference drew to a close, lifelong friend Terry Silverstone, from Kingston, Richmond & Twickenham LPC, took the opportunity to heap praise on "one of the greatest pharmacists of the last 40 years" with an, on the whole, gushing send-off.

The seven or so hours in between saw healthy, but not particularly heated, debate on the burning issues facing pharmacy in 2007. Members took to the podium to

propose 14 resolutions on topics such as MURs, remuneration and reimbursement and direct to pharmacy distribution.

Most, however, didn't get as far as being debated. As Mr Andrews himself remarked over lunch, "this used to be an excuse to give the executive a kicking". A reflection, perhaps, on the good job PSNC has done over the last few years, or simply delegate apathy to the conference format?

Either way, in her speech, PSNC chief executive Sue Sharpe predicted "another significant year for PSNC and community pharmacy". The feeling among delegates as they left to prepare for dinner was that it was hard to argue with her.



## Sue Sharpe on...

**Category M:** "There continue to be occasions when products can't be purchased at or below the category M price. Adjustments in market prices take time, and these events are unavoidable. But the DH does set the level of reimbursement price substantially above the purchase price that it gets using historical information available to it from manufacturers."

**Restrictions on ZD status:** "In discussions with the DH it has been agreed that the changes must be cost neutral to pharmacy, and we were able to ensure that this was the case. That is not to say that we're content with the new arrangements. We do

not support the current position where clawback is applied in circumstances where no discount was given to contractors."

**DTP:** "The Pfizer arrangements remove pharmacy's ability to choose which supplier to use. This was not welcome. PSNC wrote with the NPA to the OFT in October requesting an investigation, and a large number of organisations and individuals also wrote to complain. The OFT has not yet decided whether to investigate the new arrangements. We hope they will, and have been in contact with the OFT, most recently last week. This is a very significant issue for pharmacy. Other manufacturers are waiting to follow, with arrangements which could end the traditional wholesale model. And I believe that

we could be set for very substantial and adverse changes in the distribution system during the next 12 months. The present full line wholesale system on which all pharmacists depend to be able to meet patients' needs, and our ability to source even very rarely used medicines for patients promptly and easily, could come under real threat.

"The latest news is the OFT expects to decide whether to investigate early next month. It will not end there of course, it will take some time."

**Implementation of the contract:** "Overall, reports suggest all is pretty smooth now. Many PCTs had their eye off the ball over the last 12 months and some elements of the framework, such as public health, have not been fully utilised



It may be impossible to avoid making a loss on some items

## LPCs debate

### Changes to ZD: dispensing items at a loss

**Lindsay McClure**, head of information services, PSNC: "We are confident these changes were cost neutral, but we are concerned about the impact on individual contractors."

**Mike Dent**, head of finance, PSNC: "It may be impossible to avoid making a loss on some items. It's unlikely we will ever be able to eradicate it totally."

**Nye Patel**, Lambeth, Southwark & Lewisham LPC: "I'd love to see the figures that show it is cost neutral."

**Sue Sharpe**, chief executive, PSNC: "It is our policy already that nothing is dispensed at a loss. What these are all indicating are weaknesses in the PPRS system. Manufacturers are saying 'here is an opportunity for us to cut costs. Here we can make a quick gain by not putting the 12.5 per cent'. This is a problem that we have to deal with the DH on."

### The Health Act: the role of the responsible pharmacist

**John Hewitt**, Bexley, Bromley & Greenwich LPC: "The new Health Act has many flaws. It is going to cause an end to new blood coming into the industry. When somebody decides you don't need a pharmacist at the pharmacy, we've had it. I believe the Health Act could be very bad news for pharmacy and pharmacists."

**Gary Jones**, Berkshire LPC: "All of the good things pharmacists do will be threatened. We must resist this. We must make sure we protect our services."

**Mike Holden**, Hampshire & Isle of Wight LPC: "It is dangerous. If there is one thing that should bring this profession together it is this Act. I ask PSNC to declare our views on this and not sit on its backside."

**Sue Sharpe**, chief executive, PSNC: "It is something we still have in hand."

### The challenge of local commissioning

**Barbara Parson**, head of pharmacy practice, PSNC: "We're very concerned. At the moment we haven't got a good example of pharmacy services commissioned through practice-based commissioning."

**Mike Holden**, Hampshire & Isle Of Wight LPC: "There is a problem with evidence of delivery. There is a bit of work to be done around that."

**Gary Choo**, Bradford LPC: "I think we're getting too hung up on PBC."

everywhere. Repeat dispensing continues to fall victim to the slow implementation of the electronic prescription service."

**MUR forms:** "Our aim is to make them easier for pharmacists to use and to allow GPs to identify relevant issues more easily. We've had excellent and helpful contributions from our consultation, and further changes have now been made. The latest draft is just about to be sent out for volunteer testing."

**New contract workbook:** "We will shortly be producing another edition and are just awaiting completion of certain elements before finalising the text and getting it out to you."

**Galbraith Review:** "I know her inquiry is looking not simply at control of entry, but at procurement

of NHS pharmacy services. She is to report before the end of the month, and I quote 'to inform formal consultation'. This process has the express aim of developing PCTs' power to procure pharmacy services."

"For PSNC this is worrying. We've had two meetings with Anne Galbraith, and have stressed the value of and the need for a national contract. We've proposed a framework for future consideration of pharmacy applications that supports service planning. We've pressed this forcefully because we know how vulnerable contractors would be to any move away from national level contracting. We do not yet know what the form of consultation will include or how far it will range."

## Resolutions

### Additional services

**Lou Baxter**, from **Stockport LPC**, called for PSNC to negotiate for the provision of a National Patient Group Direction service for the provision of repeat medicines and appliances and urged it to agree national accreditation for enhanced services so pharmacists can work in neighbouring PCTs without the need for further accreditation. **CARRIED**

**Hertfordshire LPC** requested that the PSNC develop a new advanced service, a minor ailment service, with additional funding and appropriate accreditation. **CARRIED**

### MURs

**Terry Silverstone**, from **Kingston, Richmond & Twickenham LPC**, asked for a "heavy hitting" TV campaign encouraging people to visit their community pharmacy for MURs. **DENIED**

**Simon Moul**, from **Essex LPC**, asked PSNC to develop a communication strategy that supports the implementation and acceptance of MURs as a core NHS service. **CARRIED**

### Remuneration and reimbursement

**David Kent**, from **Camden & Islington LPC**, called for a vote of no confidence in the ability of PSNC to fairly distribute funds, available under the new pharmacy contractual framework, to pharmacy contractors without discriminating against smaller contractors. **DENIED**

**Gary Elton**, **Buckingham LPC**, proposed that PSNC pursues the introduction of a national payment for MDS systems where that patient does not qualify under DDA, but where such need is identified as necessary and is recommended by a fellow professional. **CARRIED**

**Ian Facer**, **Central Lancashire LPC**, said PSNC should persuade the DH to seek assurance from manufacturers that they will delay additional direct to pharmacy supply schemes until the impact of any initial scheme on patients and the wider distribution network has been fully evaluated. **CARRIED**

**Terry Silverstone**, **Kingston, Richmond & Lewisham LPC**, urged PSNC to continue to make strong and urgent representations to the DH about DTP supply schemes to protect community pharmacy finances and the funding of the community pharmacy contract. **CARRIED**

**Steve Brill**, **Hertfordshire LPC**, asked for any drug or appliance that is supplied in accord with NHS services that incur an out of pocket expense to be fully reimbursed. **CARRIED**

### IT

**Malcolm Goldie**, from **Gateshead & South Tyneside LPC** proposed PSNC reject government's intention of asking community pharmacists to print out electronically generated and transmitted 'FP10 tokens'. **CARRIED**

### Administration

**Mike Holden**, from **Hampshire & Isle of Wight LPC**, called on PSNC to provide and maintain a database of current and previous appeals for the use of LPCs in the preparation of robust representations in control of entry applications. **CARRIED**

**Brian Jolley**, from **Suffolk & Great Yarmouth LPC**, asked for PSNC regional members to be aligned to the strategic health authority localities. PSNC made no decision on the resolution after a tie vote and agreed to look at the issue at a later date. **NO DECISION**

**Graham Archer**, **Derbyshire LPC**, asked for a change in PCT governance arrangements to ensure that confidentiality is maintained for applications for inclusion in the pharmaceutical list, and that any employee of a PCT that has or is intending to have a personal or family interest in pharmaceutical services should neither have access to such confidential information, nor be part of the PCT's decision making process. **CARRIED**



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## David Reissner

reports on a case involving diuretics and appetite suppressants

**T**he Royal Pharmaceutical Society had to investigate an email, which arrived from an overseas consultant psychiatrist specialising in eating disorders, to say that one of his patients had recently returned from London where she obtained huge dosages of diuretics and appetite suppressants from a pharmacist without prescription.

The psychiatrist was able to identify the area of London in which the pharmacy was located, and the Society's inspectors paid a visit to the pharmacies in the area. One of those pharmacies was owned by X Limited. The superintendent pharmacist was not there and a locum, Mr V (not his real initial) was on duty. The owner of the company, Mr Y (also not his real initial) was there as well.

Mr V had never met the superintendent pharmacist of the company. He had spent most of his career working overseas and had found this particular engagement



and Mr Y, or that, as the pharmacist in personal control of the premises, he should have intervened to prevent the unlawful supply.

Mr V had been registered as a pharmacist for nearly 20 years and had never been in any kind of trouble. His case was that he had not known the frusemide was sold without prescription and the sale had been concealed from him by Mr Y. He insisted that he had not overheard any mention of frusemide.

At a Statutory Committee hearing, both the inspector and Mr V gave evidence. The inspector was asked whether he could hear what Mr V was saying in his telephone conversation in the dispensary. When the inspector replied that he could not, the committee recognised that it would have been equally unlikely that Mr V was in a position to overhear the inspector's conversation about frusemide with Mr Y.

After deliberating, the Statutory Committee decided that the case against Mr V had not been proved, and dismissed the complaint.

The Society had been powerless to bring the owner of the company before the Statutory Committee, since he was not a pharmacist. The chairman of the Statutory Committee said it was disgraceful that Mr Y had not made himself available for interview by the Society's inspectors and had not replied to correspondence.

By the time of the inquiry, the company's premises were no longer being run as a pharmacy. However, it was never made clear why the Society had failed to prosecute the owner.

Mr V's long and blameless career in pharmacy had been jeopardised, and the three years between the inspector's visit to the pharmacy and the Statutory Committee hearing had caused him many sleepless nights. Why the Society had never investigated whether the superintendent pharmacist of the company had been fulfilling his professional responsibilities remained a mystery.

**David Reissner is a partner in pharmacy law specialist Charles Russell LLP**  
david.reissner@charlesrussell.co.uk

# Hear no evil

through a locum agency. When Mr V first worked at the pharmacy, he emphasised to Mr Y that no Prescription Only Medicines and no Pharmacy medicines should be supplied without his knowledge. Mr V had been working there for just over two weeks when one of the Society's inspectors visited in the guise of a member of the public.

Mr V's recollection was that he was checking a delivery from UniChem when the inspector entered and he heard Mr Y approach the inspector to ask if he needed any help. The inspector said that he wanted something for slimming.

The pharmacy stocked a number of OTC products and Mr V took the inspector to the shelves where they were displayed. Mr V's recollection was that the telephone rang in the dispensary at that point and he went to answer it. He spoke to a patient about a possible adverse drug reaction and emerged from the

dispensary to see Mr Y at the counter, swiping the inspector's credit card. He assumed that Mr Y had sold the inspector an OTC slimming product.

The inspector's account was that when he arrived in the shop, Mr V and Mr Y were standing close together. According to the inspector, Mr Y had shown him some vitamins and supplements. The inspector then said that he had a friend who had used frusemide to lose weight. He asked if Mr Y could provide frusemide, and Mr Y agreed to sell 28 tablets for £11.50.

The sale of frusemide without a prescription was a criminal offence under the Medicines Act 1968 but the Royal Pharmaceutical Society, which has a statutory duty to enforce the Act, did not bring a prosecution. Instead, it made a complaint of misconduct against Mr V, alleging that he must have overheard the conversation between the inspector

“The sale of frusemide without a prescription was a criminal offence”



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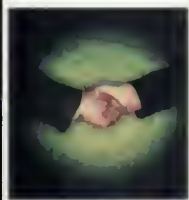
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# Howzat for Barbados

## Bon Vivreur

The island of Barbados, 166 square miles of coral and limestone, birthplace of the greatest cricketer ever (Sir Garfield St Auburn Sobers) and named by the Portuguese for the bearded fig trees that once covered the island (Barbados = the bearded ones), often gets a bad press. True, it is home to some dreadful package holiday hotels, but it is also possessed of a wonderful climate, lovely people and some very good restaurants.

Probably the most famous of these is The Cliff, situated on the island's west coast. Set (as you might expect) into the cliff side, on a variety of terraces overlooking the sea, it is a truly romantic location. From the upper level cocktail bar, one can look down at the descending terraces of tables rather as from the dress circle of a theatre or the top of a Roman amphitheatre. At night, the sparkling candles on each table glitter in serried ranks descending almost to the ocean where gas flares illuminate the shoreline.

Chef Paul Owens presents a varied carte with an emphasis on local ingredients and on Thai flavourings. For some reason – maybe the preponderance of oriental flavours and complex

I settled for linguine with prawn, mussels, garlic sauce, chilli flakes and parmesan. Yes, I know no self-respecting Italian would put cheese with fish but I enjoyed it

menu descriptions – I found making a choice difficult. In the end, for my entree, I settled for linguine with prawn, mussels, garlic sauce, chilli flakes and parmesan. Yes, I know that no self-respecting Italian would put cheese with fish but I enjoyed it. My main course of fillet of kingfish with jasmine rice, yellow Thai curry sauce, coriander pesto, zucchini and grilled pineapple relish was, however, an over complex dish having too many flavours in conflict with each other and the delicate taste of the kingfish lost in the m  l  .

The wine list is extensive, with a mouth watering claret selection (including a very desirable 1990 Cheval Blanc at \$3,450). However, I chose a St Joseph Blanc 2000, a rarish Rh  ne wine made from the Marsanne grape, not often found on wine lists and with a full round mouthfeel and strong notes of resin and ripe pineapple – and robust enough to



White chocolate mousse, wrapped in dark chocolate with glazed raspberries, was a surprisingly flavourless dessert but the 2002 Recioto I chose to accompany it added pizzazz; and full marks to the sommelier for putting this little known sweet Italian Valpolicella on the list. Maybe Mr Plonker will review these Veronese 'raisin wines' in one of his features in this magazine.

From the moment the car valets greeted me, service was efficient and friendly throughout and as I lingered over the last of my wine watching the moonlight on the water I thought of all the stressed, hard working pharmacists at home who, instead of spending their evening watching the latest version of 'Pimp my Apprentice' on TV, would benefit from a brief, restorative trip to Barbados. Hence this review as encouragement!

### Would I go here again?

The food is not quite out of the top drawer (and I thought it better a year ago) and the experience expensive, but the location is superb and overall impact excellent. I definitely recommend it. Take the love of your life.

### What would I change?

The menu needs to be simplified and the reliance on Thai flavourings lessened

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| Number of sets @ £41.13 (inc VAT) | ..... | £..... |

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Name:.....

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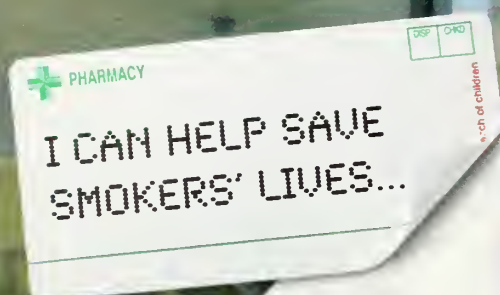
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nicotine

**NiQuitin CO 2mg/4mg Lozenge and Mint Lozenge (nicotine).** See SPC for full information. For relief of nicotine withdrawal symptoms during smoking cessation. **Dosage:** Adults: 4mg if smoke within 30 minutes of waking. 2mg if longer. Weeks 1 to 6; 1 lozenge every 1 to 2 hours (min. 9 max. 15/day). Weeks 7 to 9; 1 lozenge every 2 to 4 hours, weeks 10 to 12; 1 lozenge every 4 to 8 hours. Weeks 13-24; 1 to 2 lozenges per day only when strongly tempted to smoke. **Contraindications/precautions:** Hypersensitivity, cardiovascular disease, urticaria, severe renal/hepatic impairment, polycythemia, hyperthyroidism, diabetes, phenylketonuria, low sodium diet. Swallowed lozenges may exacerbate oesophagitis, gastric/peptic ulcer. **Side effects:** Depression, irritability, drowsiness, dizziness, headache, dizziness, cough, cold, Nausea, hiccup, flatulence, GI disturbance, allergic reactions, oral irritation/ulceration, nightmares, restlessness, mood change, pharyngitis, thirst,

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